

# Care of Critically Ill & Critically Injured Children Quality Review Visit

## Walsall Healthcare NHS Trust

Visit Date: 25<sup>th</sup> September 2018

Report Date: November 2018

*Images courtesy of NHS Photo Library and Sandwell and West Birmingham Hospitals NHS Trust*



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## INTRODUCTION

This short report presents the findings of the review of the care of Critically Ill and Critically Injured Children that took place on 25th September 2018. The review visit was commissioned by the West Midlands Paediatric Critical Care Network (WMPCCN), on behalf of commissioners and NHS England who have responsibility for making recommendations on future provision for the delivery of paediatric critical care. This review programme links to both a National Paediatric Critical Care Review and a West Midlands Paediatric Critical Care CQUIN. The CQUIN outlined a requirement for all West Midlands children's services to be assessed against the WMQRS / Paediatric Intensive Care Society (2016) Standards for the Care of Critically Ill Children (v.5) by July 2017.

The purpose of the visit was to validate the self-assessments made by the acute Trust, and to review the pathway for critically ill children attending the Emergency Department and children's assessment unit through to inpatient and high dependency inpatient areas where applicable. As part of the WMPCCN programme, information was also gathered about existing capacity to provide paediatric high dependency care at a local level, and the plans that may be required to deliver a higher level of paediatric critical care nearer to the patient's home in the future. Only a select number of Quality Standards were reviewed during this visit. The Quality Standards identified were agreed by the WMPCCN as being important to provide the information required to inform commissioners as part of the National CQUIN for 2017/18. The review visit consisted of a half-day visit, during which reviewers looked at evidence against the self-assessment submitted, met with the lead team for children's services and viewed facilities. This review programme was therefore not as in-depth as the Critically Ill and Critically Injured Children peer review programmes undertaken across the West Midlands in previous years, but was designed to provide specific assurances.

The aim of the standards and the review programme is to help providers and commissioners of services to improve clinical outcomes and service users' and carers' experiences by improving the quality of services. The report also gives external assurance of the care, which can be used as part of the organisations' Quality Accounts. For commissioners, the report gives assurance of the quality of services commissioned and identifies areas where developments may be needed.

The report reflects the situation at the time of the visit. The text of this report identifies the main issues raised during the course of the visit. Any immediate risks identified include the Trust's response, and WMQRS's response to any actions taken to mitigate the risk. Appendix 1 lists the visiting team that reviewed the services at Walsall Healthcare NHS Trust. Appendix 2 contains the details of compliance with each of the standards and the percentage of standards met.

This report describes services provided or commissioned by the following organisations:

- Walsall Healthcare NHS Trust
- NHS Walsall Clinical Commissioning Group

Most of the issues identified by quality reviews can be resolved by providers' and commissioners' own governance arrangements. Many can be tackled by the use of appropriate service improvement approaches; some require commissioner input. Individual organisations are responsible for taking action and monitoring this through their usual governance mechanisms. The lead commissioner for the service concerned is responsible for ensuring action plans are in place and monitoring their implementation, liaising, as appropriate, with other commissioners, including commissioners of primary care. The lead commissioner in relation to this report is NHS Walsall Clinical Commissioning Group.

## ABOUT WEST MIDLANDS QUALITY REVIEW SERVICE

WMQRS is a collaborative venture between NHS organisations in the West Midlands to help improve the quality of health services by developing evidence-based Quality Standards, carrying out developmental and supportive quality reviews (often through peer review visits), producing comparative information on the quality of services and providing development and learning for all involved.

Expected outcomes are better quality, safety and clinical outcomes, better patient and carer experience, organisations with better information about the quality of clinical services, and organisations with more confidence and competence in reviewing the quality of clinical services. More detail about the work of WMQRS is available on [www.wmqrs.nhs.uk](http://www.wmqrs.nhs.uk)

## ACKNOWLEDGMENTS

West Midlands Quality Review Service and West Midlands Paediatric Critical Care Network would like to thank the staff and service users and carers of Walsall Healthcare NHS Trust for their hard work in preparing for the review and for their kindness and helpfulness during the course of the visit. Thanks are also due to the visiting team and their employing organisations for the time and expertise they contributed to this review.

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# CARE OF CRITICALLY ILL AND CRITICALLY INJURED CHILDREN

## TRUST-WIDE

### General Comments and Achievements

This review looked at the care of critically ill and critically injured children in the Emergency Department, Children's Assessment Unit, inpatient ward and high dependency care unit at Walsall Healthcare NHS Trust. Annual activity levels at the time of the review were 12,000 Children's Emergency Department (CED) attendances, with 8,000 child attendances at the adjacent Urgent Care Centre. Paediatric anaesthesia and surgery were not included in this review.

All staff who met with the reviewing team were enthusiastic, proud and working hard to improve the services offered. The paediatric service and CED were part of different directorates, but staff from the CED commented on the good relationships between the areas, and were particularly appreciative of the support available from the ward.

Good child and carer involvement in the paediatric services was evident, with parents and children being involved in staff recruitment.

Paediatric consultants were on site between 9am and 5pm, with additional consultants being available between 11am and 7pm Monday to Friday. On three days a week there was consultant cover on site until 9.30pm. A paediatric consultant with a specialist interest in emergency medicine was due to commence in December 2018 and would spend 50% of their time in the CED. Out of hours consultants were available on call and were supported by two middle grade clinicians who covered paediatrics and the neonatal service.

Some comments in the Trust-wide section of this report apply to more than one service and are not duplicated in other areas of the report.

### Good Practice

1. The work the Trust had undertaken to improve the support for children with mental health issues was very good.
  - a. Clinical support workers who had completed mental health first aid training were rostered to provide one to one care for children who were admitted for assessment and treatment.
  - b. One clinical support worker had also undertaken more in-depth mental health training.
  - c. Staff had undertaken skills-based training on risk management for suicide prevention (STORM training). Competence-based training covering children and adolescents with mental health needs had also been completed by ward staff.
  - d. Steps had been taken to provide a safer environment for children by the creation of anti-ligature cubicles in the PAU and one on the inpatient ward.
2. The transfer policies for in-hospital, inter-hospital and time critical transfers were very clear, detailing who to contact and what staff should consider in order to maintain the safety of the child before and during transfers to other areas.
3. The resuscitation and stabilisation policy was very comprehensive. The policy was also very clear about how to access support and guidance for the management of a difficult airway.

## Immediate Risks<sup>1</sup>

### 1. Children's Emergency Department staffing

The CED had been developed to provide a separate area with a waiting room, and three rooms for triage and treatment. The CED was staffed by one registered children's nurse and a support worker. Reviewers were very concerned about the registered children's nurse staffing levels to ensure appropriate care for children, particularly as, while children were receiving treatment in any of the rooms, the nurse was then not available to triage children within 15 minutes of arrival or to have oversight of children waiting in the department. Reviewers were also very concerned that when the registered children's nurse was called to a paediatric resuscitation in the main ED (at the other end of the department), this would leave only a support worker in the CED. Reviewers were told that if the CED was busy, then an ED nurse would support the paediatric resuscitation and the nurse would have to return to the CED.

## Concerns

### 1. Resuscitation training

- a. From the evidence seen, eight out of thirteen anaesthetists had advanced resuscitation and life support training, but it was not clear if all of the anaesthetists on the on-call rota were competent in the intubation of young children and in leading a paediatric resuscitation.
- b. One out of the six registered children's nurses working in the CED did not have up to date advanced paediatric resuscitation and life support competences. Reviewers were particularly concerned as, at the time of the visit, the CED only had one registered children's nurse on duty each shift.

### 2. Emergency Department competence framework

A competence framework was not yet in place for adult ED nurses or paediatric nurses from the ward who would provide cover to the CED.

## Further Consideration

1. The paediatric resuscitation trolley was stored in the main ED, and reviewers suggested that the team should review whether an additional trolley should be available in the CED, especially as the resuscitation area was at the other end of the adult ED.
2. Children were triaged and seen in order of priority. However, the pathway for a child not categorised as urgent appeared to result in the child being in the department for a considerable time. Children were included in the queue (electronic) with adult patients and seen in order of priority, which meant that they were often waiting sometime in the department. Reviewers were also told that the team had tried to address the waiting times for medical assessment by having an allocated member of the medical staff, but it was often a junior member of the medical team and therefore the child would then have to wait for a further review by a middle grade clinician or consultant. Reviewers considered that this practice was unusual and created unnecessary delays for children, as it was more common for children to be in a separate queue for medical assessment.

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<sup>1</sup> **Trust Response to Immediate Risk:** Immediate action was taken by Walsall Healthcare Trust following the feedback provided to the team which was escalated to the Executive Team on the 25th September 2018. With immediate effect actions were taken to ensure the CED had a Registered children's nurse on duty at all times, as well as a second registered practitioner; this is a Registered Nurse from the Emergency Department as well as the Health Care Support worker. This means that the CED is never left without a registered practitioner in the Department. There are 6.6WTE Registered children's nurses in CED, with an additional 2 WTE nurses commencing in the Trust in January 2019 and an advert is already out for the additional staffing to ensure that going forward 2 Registered children's nurses will be rostered on duty over each 24-hour period. An escalation process to the Paediatrics is also in place to ensure that any staffing gaps in CED regarding registered children's nursing staff which cannot be resolved by the Emergency Department are escalated and resolved by the reallocation of a registered children's nurse from the Paediatric ward/Paediatric Assessment Unit.

**WMQRS Response to Trust action:** We have now considered your response and can confirm that the actions as described will address the immediate risk identified during the peer review visit.

## CHILDREN'S EMERGENCY DEPARTMENT

### General Comments and Achievements

Since the last visit in 2013 the children's emergency department had been separated from the main emergency department and was open 24 hours a day. The department consisted of three rooms and a separate waiting area accessed by a key code lock. The entrance to the waiting room was via the main ED entrance. The department was staffed by one registered children's nurse and healthcare support worker, who worked 12-hour shifts. A paediatric resuscitation area was included in the main adult emergency department.

See also Trust-wide section of the report (under General Comments).

### Good Practice

1. Reviewers were impressed with what the new ED sister had achieved in her short time in the post, and she clearly had further plans for improving the care of children attending the CED and the adult ED.
2. See also Trust-wide section of the report (under Good Practice).

**Immediate Risks:** See Trust-wide section of the report (under Immediate Risks).

### Concerns

#### 1. Initial clinical assessment

At the time of the visit, a brief clinical assessment including observations was not always possible within 15 minutes of arrival because of staffing levels in the CED (see also the Trust-wide section of the report under Immediate Risks). Staff who spoke to reviewers said that the data showed that children waited an average of 26 minutes to be seen. Reviewers were concerned that children could deteriorate during this time.

2. See also Trust-wide section of the report (under Concerns).

### Further Consideration

1. On the day of the visit reviewers observed an adult patient being cared for in the paediatric resuscitation area when the other two adult trolleys were vacant. At the time of the visit the reviewers were told that this should not have happened, and that staff had been instructed otherwise when the patient arrived. Later, reviewers were told that there had been two other patients in the resuscitation area when the third patient arrived. It was not clear why the adult patient had not been moved when a space had become free. Reviewers considered that it may be helpful to reiterate to staff the admission policy to the area.
2. Reviewers considered that the ED may wish to consider whether the good layout of the stabilisation rooms on PAU and the ward could be replicated in the ED.

## PAEDIATRIC ASSESSMENT UNIT (PAU), INPATIENT WARD AND PAEDIATRIC HIGH DEPENDENCY UNIT

### General Comments and Achievements

All inpatient care was provided on the inpatient ward, which consisted of 21 beds with an additional 6-bedded assessment unit. Staff clearly worked well together and the environment on the ward was bright and welcoming.

See also Trust-wide section of the report (under General Comments).

### Good Practice

1. Reviewers were particularly impressed with the development of a 'sick and quick' ward round that was undertaken at 8am each morning to see sick children quickly and review their treatment plans, and review any children about whom the nursing staff had concerns. A formal ward round would then take place at 10am and a later review at 3pm.

2. Stabilisation rooms on the PAU and the ward were well designed. The rooms were spacious, and the equipment filed and indexed. The set up was mirrored in the two areas, which meant that staff were familiar with the layout in an emergency.
3. The facilities and environment were excellent and child friendly, and included several areas for families, a sensory room and an adolescent area. The furnishings in the cubicles also excellent.
4. See also Trust-wide section of the report (under Good Practice).

**Immediate Risks:** None

#### **Concerns**

1. See Trust-wide section of the report (under Concerns).

#### **Further Consideration**

1. See Trust-wide section of the report (under Further Consideration).

### **EXISTING HDU CARE AND PLANS FOR THE FUTURE**

As part of the visit the WMPCCN were keen to hear from staff about their views on the future delivery of critical care for children across the region.

At the time of the visit, HDU care could be provided for children of any age who required hi-flow nasal cannula oxygen. Bubble continuous positive airway pressure (Bubble CPAP) ventilation could be delivered, but since the implementation of hi-flow oxygen this had not been required. Children with tracheostomies would only be cared for whilst awaiting transfer to a regional unit.

Non-invasive mask continuous positive airway pressure (CPAP) or bilevel positive airway pressure (BiPAP) was not provided. The team considered that a review of the workforce and additional training would be required to ensure there were sufficient staff who were both competent and confident to deliver this level of care for children.

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## APPENDIX 1 MEMBERSHIP OF VISITING TEAM

Visiting Team		
Dr Andrea Cooper	PICU Consultant and Consultant on the Transport Team (KIDS)	Birmingham Women's and Children's NHS Foundation Trust - Birmingham Children's Hospital
Aimee Haynes	Network Governance Administrator	KIDS/NTS Retrieval Service; Birmingham Women's and Children's NHS Foundation Trust
Julie Plant	Senior Matron, Children's Services Directorate	The Royal Wolverhampton NHS Trust
Alison Warren	Clinical Matron for Children and Young People's Services & Nursing Lead for Resuscitation	The Royal Orthopaedic Hospital NHS Foundation Trust

WMQRS Team		
Sarah Broomhead	Assistant Director	West Midlands Quality Review Service

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## APPENDIX 2 COMPLIANCE WITH THE QUALITY STANDARDS

Analyses of percentage compliance with the Quality Standards should be viewed with caution as they give the same weight to each of the Quality Standards. Also, the number of Quality Standards applicable to each service varies depending on the nature of the service provided. Percentage compliance also takes no account of 'working towards' a particular Quality Standard. Reviewers often comment that it is better to have a 'No, but', where there is real commitment to achieving a particular standard, than a 'Yes, but' where a 'box has been ticked' but the commitment to implementation is lacking. With these caveats, table 1 summarises the percentage compliance for each of the services reviewed.

**Table 1 - Percentage of Quality Standards met**

Details of compliance with individual Quality Standards can be found in a separate document.

Service	Number of applicable QS	Number of QS met	% met
Hospital-wide	10	7	70
Emergency Department	20	16	80
Children's Assessment Service	22	22	100
Integrated IP & L1PCCU – Ward C2	29	29	100
<b>Health Economy</b>	<b>81</b>	<b>74</b>	<b>91</b>

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## HOSPITAL-WIDE

Ref	Standard	Met?	Reviewer's comments
HW-201	<p><b>Board-Level Lead for Children</b></p> <p>A Board-level lead for children's services should be identified.</p>	Y	
HW-202	<p><b>Clinical Leads</b></p> <p>The Board-level lead for children's services should ensure that the following leads for the care of children have been identified:</p> <ol style="list-style-type: none"> <li>Lead consultants and nurses for each of the areas where children may be critically ill (QS **-201)</li> <li>Lead consultant for paediatric critical care</li> <li>Lead consultant for surgery in children (if applicable)</li> <li>Lead consultant for trauma in children (if applicable)</li> <li>Lead anaesthetist for children (QS A-201)</li> <li>Lead anaesthetist for paediatric critical care (QS A-202)</li> <li>Lead GICU consultant for children (QS A-203) (if applicable)</li> <li>Lead consultant/s and lead nurse/s for the Specialist Paediatric Transport Service (QS T-201) (if applicable)</li> <li>Lead consultant and lead nurse and for safeguarding children</li> <li>Lead allied health professional for the care of critically ill children</li> </ol>	Y	
HW-203	<p><b>Hospital Wide Group</b></p> <p>Hospitals providing hospital services for children should have a single group responsible for the coordination and development of care of critically ill and critically injured children. The membership of this group should include all nominated leads (QS HW-202) and the Resuscitation Officer with lead responsibility for children.</p> <p>The accountability of the group should include the Hospital Lead for children's services (QS HW-201). The relationship of the group to the Trust's mechanisms for safeguarding children and clinical governance issues relating to children should be clear.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
HW-204	<p><b>Paediatric Resuscitation Team</b></p> <p>A paediatric resuscitation team should be immediately available at all times, comprising at least three people:</p> <ol style="list-style-type: none"> <li>A Team Leader with up to date advanced paediatric resuscitation and life support knowledge and competences and at least Level 1 RCPCH (or equivalent) competences (QS PM-203)</li> <li>A second registered healthcare professional with up to date advanced paediatric resuscitation and life support competences</li> </ol> <p>An anaesthetist, or other practitioner, with up to date competences in advanced paediatric resuscitation and life support and advanced airway management</p>	N	A rota was in place for 24hr cover, 8 out of 13 Consultants had up to date advanced paediatric resuscitation and life support training, but it was not clear if all the anaesthetists on the on- call rota had appropriate competences. See main report.
HW-205	<p><b>Consultant Anaesthetist 24 Hour Cover</b></p> <p>A consultant anaesthetist with up to date competences in advanced paediatric resuscitation and life support and advanced paediatric airway management who is able to attend the hospital within 30 minutes and does not have responsibilities to other hospital sites should be available 24/7.</p>	N	A rota was in place for 24hr cover, 8 out of 13 Consultants had up to date advanced paediatric resuscitation and life support training, but it was not clear if all the anaesthetists on the on- call rota had appropriate competences. See main report.
HW-206	<p><b>Other Clinical Areas</b></p> <p>Staff in other clinical areas where children may be critically ill, such as imaging and paediatric out-patient departments, should have basic paediatric resuscitation and life support training.</p>	Y	Critically ill children were all escorted to other areas.
HW-401	<p><b>Paediatric Resuscitation Team – Equipment</b></p> <p>The paediatric resuscitation team should have immediate access to appropriate drugs and equipment which are checked in accordance with local policy.</p>	Y	
HW-501	<p><b>Resuscitation and Stabilisation</b></p> <p>Protocols should be in use covering resuscitation and stabilisation, including:</p> <ol style="list-style-type: none"> <li>Alerting the paediatric resuscitation team</li> <li>Arrangements for accessing support for difficult airway management</li> <li>Stabilisation and ongoing care</li> <li>Care of parents during the resuscitation of a child</li> </ol>	Y	

Ref	Standard	Met?	Reviewer's comments
HW-598	<p><b>Trust-Wide Guidelines</b></p> <p>The following Trust-Wide guidelines should be in use:</p> <ul style="list-style-type: none"> <li>a. Consent</li> <li>b. Organ and tissue donation</li> <li>c. Palliative care</li> <li>d. Bereavement</li> <li>e. Staff acting outside their area of competence covering:</li> <li>f. Exceptional circumstances when this may occur</li> <li>g. Staff responsibilities</li> <li>h. Reporting of event as an untoward clinical incident</li> <li>i. Support for staff</li> </ul>	N	<p>The organ donation policy was out of date, and the policy covering bereavement was in the process of being reviewed. A policy covering staff acting outside their area of competence was not yet in place.</p>
HW-602	<p><b>Paediatric Critical Care Operational Delivery Network Involvement</b></p> <p>At least one representative from the Trust should attend each meeting of the Paediatric Critical Care Operational Delivery Network. Information about the work of the network should be disseminated to all staff involved in the provision of critical care for children</p>	Y	

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## EMERGENCY DEPARTMENT

Ref	Standard	Met?	Reviewer's comments
ED-201	<p><b>Lead Consultant and Lead Nurse</b></p> <p>A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.</p>	Y	
ED-202	<p><b>Consultant Staffing</b></p> <p>a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7</p> <p>b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children</p>	Y	
ED-203	<p><b>'Middle Grade' Clinician</b></p> <p>A 'middle grade' clinician with the following competences should be immediately available at all times:</p> <p>a. Advanced paediatric resuscitation and life support</p> <p>b. Assessment of the ill child and recognition of serious illness and injury</p> <p>c. Initiation of appropriate immediate treatment</p> <p>d. Prescribing and administering resuscitation and other appropriate drugs</p> <p>e. Provision of appropriate pain management</p> <p>f. Effective communication with children and their families</p> <p>g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant</p> <p>A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be Specialist Trainee 4 (ST4) or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.</p>	Y	Seven out of nine middle grade clinicians had advanced paediatric resuscitation and life support competences. Of the other two staff listed, one was out of date and one unknown.

Ref	Standard	Met?	Reviewer's comments
ED-206	<p><b>Competence Framework and Training Plan – Staff Providing Bedside Care</b></p> <p>A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including:</p> <ul style="list-style-type: none"> <li>a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS ED-208) and expected input to the paediatric resuscitation team (QS HW-204)</li> <li>b. Care and rehabilitation of children with trauma (if applicable)</li> <li>c. Care of children needing surgery (if applicable)</li> <li>d. Use of equipment as expected for their role</li> <li>e. Care of children with acute mental health problems</li> </ul>	N	<p>A competence framework was not yet place.</p> <p>One out of the six registered children's nurses did not have up to date advanced paediatric resuscitation and life support competences.</p>
ED-207	<p><b>Staffing Levels: Bedside Care</b></p> <p>Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation C12policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved:</p> <ul style="list-style-type: none"> <li>a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift</li> <li>b. At least one registered children's nurses on duty at all times in each area</li> </ul>	N	<p>See immediate risk section of the report.</p>

Ref	Standard	Met?	Reviewer's comments
ED-209	<p><b>Other Staffing</b></p> <p>The following staff should be available:</p> <ul style="list-style-type: none"> <li>a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7)</li> <li>b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7)</li> <li>c. Access to dietetic service (at least 5/7)</li> <li>d. Access to a liaison health worker for children with mental health needs (7/7)</li> <li>e. Access to staff with competences in psychological support (at least 5/7)</li> </ul>	Y	'a' was not applicable as the ED did not see more than 16,000 children per year. Advice was available from the ward team.
ED-211	<p><b>ED Liaison Paediatrician</b></p> <p>A nominated paediatric consultant should be responsible for liaison with the nominated Emergency Department consultant (QS ED-201).</p>	Y	
ED-212	<p><b>ED Sub-speciality Trained Consultant</b></p> <p>Emergency Departments seeing 16,000 or more child attendances per year should have a consultant with sub-specialty training in paediatric emergency medicine.</p>	N/A	Attendances at the ED were 12,000
ED-301	<p><b>Imaging Services</b></p> <p>24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Hospital should have arrangements for review of imaging by a paediatric radiologist.</p>	Y	
ED-401	<p><b>Resuscitation Equipment</b></p> <p>An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.</p>	N	The resuscitation trolley was in the adult ED. Equipment was not available in the triage area - see main report.
ED-402	<p><b>Grab Bag'</b></p> <p>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
ED-501	<p><b>Initial Assessment</b></p> <p>A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.</p>	N	Staff who spoke to Reviewers said that data showed children waited an average of 26 minutes to be seen.
ED-502	<p><b>Paediatric Early Warning System</b></p> <p>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.</p>	Y	
ED-503	<p><b>Resuscitation and Stabilisation</b></p> <p>Hospital-Wide protocols for resuscitation and stabilisation should be in use, including:</p> <ol style="list-style-type: none"> <li>Alerting the paediatric resuscitation team</li> <li>Arrangements for accessing support for difficult airway management</li> <li>Stabilisation and ongoing care</li> <li>Care of parents during the resuscitation of a child</li> </ol>	Y	
ED-504	<p><b>Paediatric Advice</b></p> <p>Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.</p>	Y	
ED-505	<p><b>Clinical Guidelines</b></p> <p>The following clinical guidelines should be in use:</p> <ol style="list-style-type: none"> <li>Treatment of all major conditions, including: <ol style="list-style-type: none"> <li>acute respiratory failure (including bronchiolitis and asthma)</li> <li>sepsis (including septic shock and meningococcal infection)</li> <li>management of diabetic ketoacidosis</li> <li>seizures and status epilepticus</li> <li>trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable)</li> <li>burns and scalds</li> <li>cardiac arrhythmia</li> <li>upper airway obstruction</li> </ol> </li> <li>Management of acutely distressed children, including use of restraint</li> <li>Drug administration and medicines management</li> <li>Pain management</li> <li>Procedural sedation and analgesia</li> <li>Infection control and antibiotic prescribing</li> <li>Tissue viability, including extravasation</li> </ol>	Y	Local guidance and Paediatrics in Partnership guidance was in place.

Ref	Standard	Met?	Reviewer's comments
ED-506	<p><b>PCC Transfer Guidelines</b></p> <p>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:</p> <ul style="list-style-type: none"> <li>a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information</li> <li>b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service</li> <li>c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained</li> </ul>	Y	
ED-507	<p><b>In-hospital Transfer Guidelines</b></p> <p>Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.</p>	Y	
ED-508	<p><b>Inter-hospital Transfer Guidelines</b></p> <p>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:</p> <ul style="list-style-type: none"> <li>a. Types of patients transferred</li> <li>b. Composition and expected competences of the escort team</li> <li>c. Drugs and equipment required</li> <li>d. Restraint of children, equipment and staff during transfer</li> <li>e. Monitoring during transfer</li> </ul>	Y	

Ref	Standard	Met?	Reviewer's comments
ED-509	<p><b>Time-Critical Transfer Guidelines</b></p> <p>Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include:</p> <ol style="list-style-type: none"> <li>Securing advice from the Specialist Paediatric Transport Service (QS ED-506)</li> <li>Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management</li> <li>Indemnity for escort team</li> <li>Availability of drugs and equipment, checked in accordance with local policy (QS ED-402)</li> <li>Arrangements for emergency transport with a local ambulance service and the air ambulance</li> <li>Arrangements for ensuring restraint of children, equipment and staff during transfer</li> </ol>	Y	
ED-798	<p><b>Review and Learning</b></p> <p>The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.</p>	Y	

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## CHILDREN'S ASSESSMENT SERVICE

Ref	Standard	Met?	Reviewer's comments
CA-201	<p><b>Lead Consultant and Lead Nurse</b></p> <p>A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.</p>	Y	
CA-202	<p><b>Consultant Staffing</b></p> <p>a. A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7</p> <p>b. All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children</p>	Y	
CA-203	<p><b>'Middle Grade' Clinician</b></p> <p>A 'middle grade' clinician with the following competences should be immediately available at all times:</p> <p>a. Advanced paediatric resuscitation and life support</p> <p>b. Assessment of the ill child and recognition of serious illness and injury</p> <p>c. Initiation of appropriate immediate treatment</p> <p>d. Prescribing and administering resuscitation and other appropriate drugs</p> <p>e. Provision of appropriate pain management</p> <p>f. Effective communication with children and their families</p> <p>g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant</p> <p>A clinician with at least Level 1 RCPCH (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-206	<p><b>Competence Framework and Training Plan – Staff Providing Bedside Care</b></p> <p>A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including:</p> <ul style="list-style-type: none"> <li>a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS CA-208) and expected input to the paediatric resuscitation team (QS HW-204)</li> <li>b. Care and rehabilitation of children with trauma (if applicable)</li> <li>c. Care of children needing surgery (if applicable)</li> <li>d. Use of equipment as expected for their role</li> <li>e. Care of children with acute mental health problems</li> </ul>	Y	
CA-207	<p><b>Staffing Levels: Bedside Care</b></p> <p>Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff.</p> <p>The following minimum nurse staffing levels should be achieved:</p> <ul style="list-style-type: none"> <li>a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift</li> <li>b. At least two registered children's nurses on duty at all times in each area</li> </ul>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-209	<p><b>Other Staffing</b></p> <p>The following staff should be available:</p> <ul style="list-style-type: none"> <li>a. Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7)</li> <li>b. On-call access to pharmacy and physiotherapy services able to support the care of children (24/7)</li> <li>c. Access to dietetic service (at least 5/7)</li> <li>d. Access to a liaison health worker for children with mental health needs (7/7)</li> <li>e. Access to staff with competences in psychological support (at least 5/7)</li> </ul>	Y	Staff had also undertaken skills-based training on risk management for suicide prevention (STORM training).
CA-301	<p><b>Imaging Services</b></p> <p>24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Hospital should have arrangements for review of imaging by a paediatric radiologist.</p>	Y	
CA-401	<p><b>Resuscitation Equipment</b></p> <p>An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.</p>	Y	
CA-402	<p><b>'Grab Bag'</b></p> <p>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.</p>	Y	
CA-406	<p><b>'Point of Care' Testing</b></p> <p>'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.</p>	Y	
CA-501	<p><b>Initial Assessment</b></p> <p>A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.</p>	Y	
CA-502	<p><b>Paediatric Early Warning System</b></p> <p>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-503	<p><b>Resuscitation and Stabilisation</b></p> <p>Hospital-Wide protocols for resuscitation and stabilisation should be in use, including:</p> <ol style="list-style-type: none"> <li>a. Alerting the paediatric resuscitation team</li> <li>b. Arrangements for accessing support for difficult airway management</li> <li>c. Stabilisation and ongoing care</li> <li>d. Care of parents during the resuscitation of a child</li> </ol>	Y	
CA-504	<p><b>Paediatric Advice</b></p> <p>Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.</p>	N/A	
CA-505	<p><b>Clinical Guidelines</b></p> <p>The following clinical guidelines should be in use:</p> <p><b>All:</b></p> <ol style="list-style-type: none"> <li>a. Treatment of all major conditions, including: <ol style="list-style-type: none"> <li>i. acute respiratory failure (including bronchiolitis and asthma)</li> <li>ii. sepsis (including septic shock and meningococcal infection)</li> <li>iii. management of diabetic ketoacidosis</li> <li>iv. seizures and status epilepticus</li> <li>v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable)</li> <li>vi. burns and scalds</li> <li>vii. cardiac arrhythmia</li> <li>viii. upper airway obstruction</li> </ol> </li> <li>b. Management of acutely distressed children, including use of restraint</li> <li>c. Drug administration and medicines management</li> <li>d. Pain management</li> <li>e. Procedural sedation and analgesia</li> <li>f. Infection control and antibiotic prescribing</li> <li>g. Tissue viability, including extravasation</li> <li>h. Nasal high flow therapy (if used)</li> <li>i. Management of children undergoing surgery (if applicable)</li> </ol>	Y	Local guidance and Paediatrics in Partnership guidance was in place.

Ref	Standard	Met?	Reviewer's comments
CA-506	<p><b>PCC Transfer Guidelines</b></p> <p>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:</p> <ol style="list-style-type: none"> <li>Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information</li> <li>Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service</li> <li>Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained</li> </ol>	Y	
CA-507	<p><b>In-hospital Transfer Guidelines</b></p> <p>Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.</p>	Y	
CA-508	<p><b>Inter-hospital Transfer Guidelines</b></p> <p>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:</p> <ol style="list-style-type: none"> <li>Types of patients transferred</li> <li>Composition and expected competences of the escort team</li> <li>Drugs and equipment required</li> <li>Restraint of children, equipment and staff during transfer</li> <li>Monitoring during transfer</li> </ol>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-509	<p><b>Time-Critical Transfer Guidelines</b></p> <p>Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include:</p> <ol style="list-style-type: none"> <li>a. Securing advice from the Specialist Paediatric Transport Service (QS CA-506)</li> <li>b. Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management</li> <li>c. Indemnity for escort team</li> <li>d. Availability of drugs and equipment, checked in accordance with local policy (QS CA-402)</li> <li>e. Arrangements for emergency transport with a local ambulance service and the air ambulance</li> <li>f. Arrangements for ensuring restraint of children, equipment and staff during transfer</li> </ol>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-601	<p><b>Operational Policy</b></p> <p>The service should have an operational policy covering at least:</p> <ul style="list-style-type: none"> <li>a. Individualised management plans are accessible for children who have priority access to the service (where applicable)</li> <li>b. Informing the child's GP of their attendance / admission</li> <li>c. Level of staff authorised to discharge children</li> <li>d. Arrangements for consultant presence during 'times of peak activity' (7/7)</li> <li>e. Servicing and maintaining equipment, including 24 hour call out where appropriate</li> <li>f. Arrangements for a consultant-led rapid access service which can see children within 24 hours of referral</li> <li>g. Arrangements for admission within four hours of the decision to admit</li> <li>h. Types of patient admitted</li> <li>i. Review by a senior clinician within four hours of admission</li> <li>j. Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours</li> <li>k. Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff</li> <li>l. Discussion with a senior clinician prior to discharge</li> </ul>	Y	
CA-703	<p><b>Audit and Quality Improvement</b></p> <p>The service should have a rolling programme of audit, including at least:</p> <ul style="list-style-type: none"> <li>a. Audit of implementation of evidence based guidelines (QS CA-500s)</li> <li>b. Participation in agreed national and network-wide audits</li> <li>c. Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations</li> </ul>	Y	
CA-704	<p><b>Key Performance Indicators</b></p> <p>Key performance indicators should be reviewed regularly with Hospital (or equivalent) management and with commissioners.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
CA-798	<p><b>Review and Learning</b></p> <p>The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.</p>	Y	

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## INTEGRATED IN-PATIENTS & L1 PAEDIATRIC CRITICAL CARE

Ref	Standard	Met?	Reviewer's comments
L1-101	<p><b>Child-friendly Environment</b></p> <p>Children should be cared for in a defined safe and secure child-friendly environment, with age-appropriate stimulation and distraction activities.</p>	Y	
L1-102	<p><b>Parental Access and Involvement</b></p> <p>Parents should:</p> <ol style="list-style-type: none"> <li>Have access to their child at all times except when this is not in the interest of the child and family or of the privacy and confidentiality of other children and their families</li> <li>Be informed of the child's condition, care plan and emergency transfer (if necessary) and this information should be updated regularly</li> <li>Have information, encouragement and support to enable them fully to participate in decisions about, and in the care of, their child</li> </ol>	Y	
L1-201	<p><b>Lead Consultant and Lead Nurse</b></p> <p>A nominated lead consultant and lead nurse should be responsible for staffing, training, guidelines and protocols, governance and for liaison with other services. The lead nurse should be a senior children's nurse. The lead consultant and lead nurse should undertake regular clinical work within the service for which they are responsible.</p>	Y	
L1-202	<p><b>Consultant Staffing</b></p> <ol style="list-style-type: none"> <li>A consultant who is able to attend the hospital within 30 minutes and who does not have responsibilities to other hospital sites should be available 24/7</li> <li>All consultants should have up to date advanced paediatric resuscitation and life support competences and should undertake CPD of relevance to their work with critically ill and critically injured children</li> </ol>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-203	<p><b>'Middle Grade' Clinician</b></p> <p>A 'middle grade' clinician with the following competences should be immediately available at all times:</p> <ul style="list-style-type: none"> <li>a. Advanced paediatric resuscitation and life support</li> <li>b. Assessment of the ill child and recognition of serious illness and injury</li> <li>c. Initiation of appropriate immediate treatment</li> <li>d. Prescribing and administering resuscitation and other appropriate drugs</li> <li>e. Provision of appropriate pain management</li> <li>f. Effective communication with children and their families</li> <li>g. Effective communication with other members of the multi-disciplinary team, including the on-duty consultant</li> </ul> <p>A clinician with at least Level 1 RCPC (or equivalent) competences and experience should be immediately available. Doctors in training should normally be ST4 or above. Larger hospitals with several wards or departments caring for children will require more than one clinician with these competences on site 24/7.</p>	Y	
L1-205	<p><b>Medical Staff: Continuity of Care</b></p> <p>Consultant rotas should be organised to give reasonable continuity of care.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-206	<p><b>Competence Framework and Training Plan – Staff Providing Bedside Care</b></p> <p>A competence framework and training plan should ensure that all staff providing bedside care have or are working towards, and maintain, competences appropriate for their role in the service including:</p> <ul style="list-style-type: none"> <li>a. Paediatric resuscitation: All staff should have basic paediatric resuscitation and life support competences and the service should have sufficient staff with advanced paediatric resuscitation and life support competences to achieve at least the minimum staffing levels (QS L1-208) and expected input to the paediatric resuscitation team (QS HW-204)</li> <li>b. Care and rehabilitation of children with trauma (if applicable)</li> <li>c. Care of children needing surgery (if applicable)</li> <li>d. Use of equipment as expected for their role</li> <li>e. Care of children with acute mental health problems</li> <li>f. Appropriate level paediatric critical care competences: 70% of nursing staff working on the PCC Units should have appropriate level competences in paediatric critical care.</li> </ul>	Y	95% of staff had paediatric immediate life support competences or advanced paediatric resuscitation and life support (two staff were on leave).
L1-207	<p><b>Staffing Levels: Bedside Care</b></p> <p>Nursing and non-registered health care staffing levels should be appropriate for the number, dependency and case-mix of children normally cared for by the service and the lay-out of the unit. An escalation policy should show how staffing levels will respond to fluctuations in the number and dependency of patients. If staffing levels are achieved through flexible use of staff (rather than rostering), achievement of expected staffing levels should have been audited. Before starting work in the service, local induction and a review of competence for their expected role should be completed for all agency, bank and locum staff. The following minimum nurse staffing levels should be achieved:</p> <ul style="list-style-type: none"> <li>a. At least one nurse with up to date advanced paediatric resuscitation and life support competences on each shift</li> <li>b. At least two registered children's nurses on duty at all times in each area</li> <li>c. At least one nurse per shift with appropriate level competences in paediatric critical care</li> <li>d. One nurse with appropriate level competences in paediatric critical care for every two children needing Level 1 critical care</li> </ul>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-208	<p><b>New Starters</b></p> <p>Nurses and non-registered health care staff without previous paediatric critical care experience should undertake:</p> <ol style="list-style-type: none"> <li>A structured, competency-based induction programme including a minimum of 75 hours of supervised practice in the PCC Unit (or in a higher level unit)</li> <li>A programme of theoretical and bedside education and training ensuring a defined level of competency is achieved within 12 months</li> </ol> <p>Nurses and non-registered health care staff with previous paediatric critical care experience should complete local induction and a review of competence for their expected role.</p>	Y	
L1-209	<p><b>Other Staffing</b></p> <p>The following staff should be available:</p> <ol style="list-style-type: none"> <li>Appropriately qualified staff to provide support for play, mental stimulation and distraction during procedures (7/7)</li> <li>Access to a liaison health worker for children with mental health needs (7/7)</li> <li>Access to staff with competences in psychological support (at least 5/7)</li> <li>Pharmacist with paediatric competences (with time allocated at least 5/7 for work on the unit)</li> <li>Physiotherapist with paediatric competences (with time allocated at least 5/7 for work on the unit)</li> <li>On-call access to pharmacy and physiotherapy services able to support the care of children (24/7)</li> <li>Access to dietetic service (at least 5/7)</li> <li>Access to an educator for the training, education and continuing professional development of staff</li> </ol>	Y	All (5.8 wte) CSW had completed mental health first aid training. One CSW had also undertaken more in- depth mental health training. Staff had also undertaken skills-based training on risk management for suicide prevention (STORM) and had completed competences for the care of children and adolescents with mental health needs.
L1-301	<p><b>Imaging Services</b></p> <p>24 hour on site access to imaging services should be available including ultrasound and CT scanning, with reporting available within one hour. Arrangements for access to MRI should be in place. If staff with competences in reporting imaging of children are not available 24/7 then the Hospital should have arrangements for review of imaging by a paediatric radiologist.</p>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-401	<p><b>Resuscitation Equipment</b></p> <p>An appropriately designed and equipped area, or adequate mobile equipment, for resuscitation and stabilisation of critically ill children of all ages should be available. Drugs and equipment should be checked in accordance with local policy.</p>	Y	
L1-402	<p><b>'Grab Bag'</b></p> <p>Appropriate drugs and equipment for in-hospital and time-critical transfers should be immediately available and checked in accordance with local policy.</p>	Y	
L1-404	<p><b>Facilities</b></p> <p>Paediatric critical care should be provided in a designated area, distinct from children needing general paediatric care.</p>	Y	
L1-405	<p><b>Equipment</b></p> <p>Equipment, including disposables, should be appropriate for the usual number and age of children and the critical care interventions provided. Equipment should be checked in accordance with local policy.</p>	Y	
L1-406	<p><b>'Point of Care' Testing</b></p> <p>'Point of care' testing for blood gases, glucose, electrolytes and lactate should be easily available.</p>	Y	
IP-501	<p><b>Initial Assessment</b></p> <p>A protocol should be in use which ensures a brief clinical assessment within 15 minutes of arrival, including a pain score (where appropriate), and a system of prioritisation for full assessment if waiting times for full assessment exceed 15 minutes.</p>	Y	
L1-502	<p><b>Paediatric Early Warning System</b></p> <p>A system to provide early warning of deterioration of children should be in use. The system should cover observation, monitoring and escalation of care.</p>	Y	
L1-503	<p><b>Resuscitation and Stabilisation</b></p> <p>Hospital-wide protocols for resuscitation and stabilisation should be in use, including:</p> <ol style="list-style-type: none"> <li>Alerting the paediatric resuscitation team</li> <li>Arrangements for accessing support for difficult airway management</li> <li>Stabilisation and ongoing care</li> <li>Care of parents during the resuscitation of a child</li> </ol>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-504	<p><b>Paediatric Advice</b></p> <p>Guidelines on accessing advice from the local paediatric service and local paediatric critical care service should be in use in units where children are not under the care of a paediatrician.</p>	N/A	
L1-505	<p><b>Clinical Guidelines</b></p> <p>The following clinical guidelines should be in use:</p> <p><b>All:</b></p> <ol style="list-style-type: none"> <li>a. Treatment of all major conditions, including: <ol style="list-style-type: none"> <li>i. acute respiratory failure (including bronchiolitis and asthma)</li> <li>ii. sepsis (including septic shock and meningococcal infection)</li> <li>iii. management of diabetic ketoacidosis</li> <li>iv. seizures and status epilepticus</li> <li>v. trauma, including traumatic brain injury, spinal injury and rehabilitation of children following trauma (if applicable)</li> <li>vi. burns and scalds</li> <li>vii. cardiac arrhythmia</li> <li>viii. upper airway obstruction</li> </ol> </li> <li>b. Management of acutely distressed children, including use of restraint</li> <li>c. Drug administration and medicines management</li> <li>d. Pain management</li> <li>e. Procedural sedation and analgesia</li> <li>f. Infection control and antibiotic prescribing</li> <li>g. Tissue viability, including extravasation</li> <li>h. Nasal high flow therapy (if used)</li> <li>i. Management of children undergoing surgery (if applicable)</li> <li>j. Rehabilitation after critical illness (if applicable)</li> </ol>	Y	Local guidance and Paediatrics in Partnership guidance was in place.
L1-506	<p><b>PCC Transfer Guidelines</b></p> <p>Guidelines on referral to a Specialist Paediatric Transport Service should be in use, covering at least:</p> <ol style="list-style-type: none"> <li>a. Accessing advice from a Specialist Paediatric Transport Service and providing full clinical information</li> <li>b. Ensuring decisions on whether a child needs to be transferred are taken by the appropriate local consultant together with the Specialist Paediatric Transport Service</li> <li>c. Local guidelines on the maintenance of paediatric critical care until the child's condition improves or the SPTP arrives. These guidelines should stipulate the location/s in which children may be maintained</li> </ol>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-507	<p><b>In-hospital Transfer Guidelines</b></p> <p>Guidelines on transfer of seriously ill children within the hospital (for example, to or from imaging or theatre) should be in use. The guidelines should specify the escort arrangements and equipment required.</p>	Y	
L1-508	<p><b>Inter-hospital Transfer Guidelines</b></p> <p>Guidelines on transfer of children between hospitals or between hospital sites should be in use covering at least:</p> <ol style="list-style-type: none"> <li>Types of patients transferred</li> <li>Composition and expected competences of the escort team</li> <li>Drugs and equipment required</li> <li>Restraint of children, equipment and staff during transfer</li> <li>Monitoring during transfer</li> </ol>	Y	
L1-509	<p><b>Time-Critical Transfer Guidelines</b></p> <p>Guidelines should be in place for situations where emergency transfer is time-critical and waiting for the SPTS to arrive may introduce unsafe delay, for example, severe head injury, intracranial bleeding, severe thoracic vascular trauma, burns and some intra-abdominal emergencies. The guidelines should include:</p> <ol style="list-style-type: none"> <li>Securing advice from the Specialist Paediatric Transport Service (QS L1-506)</li> <li>Escort team of at least two clinical staff with appropriate training and experience. The referring consultant and senior nurse on duty should judge the appropriateness of the escorts who would normally be senior clinicians with experience and / or training in a) care of the critically ill child, b) emergency transfer and c) advanced airway management</li> <li>Indemnity for escort team</li> <li>Availability of drugs and equipment, checked in accordance with local policy (QS L1-402)</li> <li>Arrangements for emergency transport with a local ambulance service and the air ambulance</li> <li>Arrangements for ensuring restraint of children, equipment and staff during transfer</li> </ol>	Y	

Ref	Standard	Met?	Reviewer's comments
L1-601	<p><b>Operational Policy</b></p> <p>All: The service should have an operational policy covering at least:</p> <ol style="list-style-type: none"> <li>Individualised management plans are accessible for children who have priority access to the service (where applicable)</li> <li>Informing the child's GP of their attendance / admission</li> <li>Level of staff authorised to discharge children</li> <li>Arrangements for consultant presence during 'times of peak activity' (7/7)</li> <li>Servicing and maintaining equipment, including 24 hour call out where appropriate</li> <li>Arrangements for admission within four hours of the decision to admit</li> <li>Types of patient admitted</li> <li>Review by a senior clinician within four hours of admission</li> <li>Discussion with a consultant within four hours of admission</li> <li>Review by a consultant within 14 hours of admission and at least two consultant-led clinical handovers every 24 hours</li> <li>Handover of patients at each change of responsible consultant, non-consultant medical staff, nursing staff and other staff</li> <li>Discussion with a senior clinician prior to discharge</li> </ol>	Y	
L1-702	<p><b>Data Collection</b></p> <p>The service should collect:</p> <ol style="list-style-type: none"> <li>Paediatric Intensive Care Audit Network (PICANet) data</li> <li>Paediatric Critical Care Minimum Data Set for submission to Secondary Uses Service (SUS)</li> <li>'Quality Dashboard' data as recommended by the PCC Clinical Reference Group (CRG)</li> </ol>	Y	
L1-703	<p><b>Audit and Quality Improvement</b></p> <p>The service should have a rolling programme of audit, including at least:</p> <ol style="list-style-type: none"> <li>Audit of implementation of evidence based guidelines (QS L1-500s)</li> <li>Participation in agreed national and network-wide audits</li> <li>Use of the 'Urgent and Emergency Care Clinical Audit Toolkit' to review individual clinical consultations</li> </ol>	Y	'c' was not applicable

Ref	Standard	Met?	Reviewer's comments
L1-704	<p><b>Key Performance Indicators</b></p> <p>Key performance indicators should be reviewed regularly with Hospital (or equivalent) management and with commissioners.</p>	Y	
L1-798	<p><b>Review and Learning</b></p> <p>The service should have appropriate multi-disciplinary arrangements for review of, and implementing learning from, positive feedback, complaints, morbidity, mortality, transfers and clinical incidents and 'near misses'.</p>	Y	

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